

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17302

17313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First GLADYS	Middle BEATRICE	Last BOWEN	2a. DATE OF DEATH Month T2	31 Day 27	68 Year 1968	2b. HOUR P 7:40 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-1-27/1922		6. AGE (In years last birthday) 19	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert County		Md.		
10. CITY OR TOWN OF DEATH Prince Frederick Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Wife		12b. KIND OF BUSINESS OR INDUSTRY at Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Calvert	13c. CITY OR TOWN Prince Frederick	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Frank	Middle Penn	15. MOTHER'S MAIDEN NAME First Helen	Middle		Last Redding		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 212-62-1326	17. INFORMANT Mr. Norman Swann-Son-Prince Fredrick, M.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Obesity & hypertension</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>331X</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/10/68</i> , to <i>12/31/68</i> , that (I) (we) last saw the deceased alive on <i>12/31/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Weems</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12/31/68</i>			
22d. PHYSICIAN'S NAME (Type) GEORGE J. WEEMS, M. D.	22e. ADDRESS HUNTINGTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/4/1969	23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery, Wayside, Maryland	23d. LOCATION (City or Town) Wayside	(County) Maryland	(State)		
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.	ADDRESS	25a. RECD. BY REGISTRAR JAN 6 1969	25b. REGISTRAR'S SIGNATURE <i>James Juge</i>				

EX-1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17303

17314

1. DECEASED NAME (Type or Print)	First	Middle	2a. DATE KNOWN OF DEATH MATED	Month	Day	Year	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years) MONTHS YRS.	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. DEATH HOURS MIN.	10. DEATH M.
7	C	June 23 1913	55				12 10 168
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH	10c. USUAL OCCUPATION (kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
Md	USA.		Cabell	Housewife	Business		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Womps		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Womps				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md	Cabell of Womps	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Womps				
14. FATHER'S NAME	First	Middle	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Marion			Holland	Nancy		Moore	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ADDRESS 57734676 Wm Brown Dr. Apt. 402			
			Candid vascular syndrome	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4120			DUE TO, OR AS A CONSEQUENCE OF				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X	(b)	DUE TO, OR AS A CONSEQUENCE OF					
	(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Found dead in bed							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE H.W. Wald				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-14-68		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Ch. Cem		23d. LOCATION (City or Town) (County) (State) Sunderland Cal. Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 10M REV. 1/68							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17304

17315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First John	Middle Hammerbacher	Last Hammerbacher	2a. DATE OF DEATH Month 12	Day 4	Year 68	2b. HOUR A.M. 1:20		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-27-87		6. AGE (In years last birthday) 81		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0		
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Calvert	10. CITY OR TOWN OF DEATH Prince Frederick					
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Calvert	13c. CITY OR TOWN Owings	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Anna Kratz					
14. FATHER'S NAME First Hammerbacher	Middle Hammerbacher	Last Hammerbacher	15. MOTHER'S MAIDEN NAME Anna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 218 30 3914	17. INFORMANT Claude Owings	Address Owings, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from Nov. 27, 1968, to Dec. 4, 1968, that (I) (we) last saw the deceased alive on Dec. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE Page C. Jett, M. D.	22c. DATE SIGNED Dec 11 1968
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Prince Frederick, Maryland							
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE 12/7/68	23c. NAME OF CEMETERY OR CREMATORIUM Friendship Cemetery	23d. LOCATION (City or Town) Friendship	(County) Anne Arundel	(State) Md			
24. FUNERAL DIRECTOR Hutchins Funeral Home		ADDRESS Owings, Md.	25a. REC'D BY REGISTRAR DEC 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 30M REV. 1968									

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17316

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR					
Gross		Dorothy			1/227	18	10							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years for birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR					
M	Negro	7/7/04	64			Month	Day	Year	19					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH									
W. Va		U.S.A.		Capitol										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of victim's life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
Sandland		Sandland		Sanderson farm										
13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER								
W. Va		Capitol	Sandland											
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost						
Tom H. Jones					Madonna Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			ADDRESS							
No		219068136		Mrs. Jones Sandland, Va										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralyzed from waist down</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>3449</u> <u>352X</u> (b) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Had been confined to bed 9 yrs</u>														
19a. DATE OF OPERATION 1961		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/68</u>								
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (Specify)									23c. NAME OF CEMETERY OR CREMATORIAL Edmonds church		23d. LOCATION (City or Town) Chesapeake Beach, Md.		(County) <input type="checkbox"/>	(State) <input type="checkbox"/>
23b. DATE 1-1-69		ADDRESS		23e. REC'D. BY REGISTRAR DEC 30 1968		23f. REGISTRAR'S SIGNATURE Charles Judge								
24. FUNERAL DIRECTOR Leroy E. Berry Huntington, Md.														

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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21671



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

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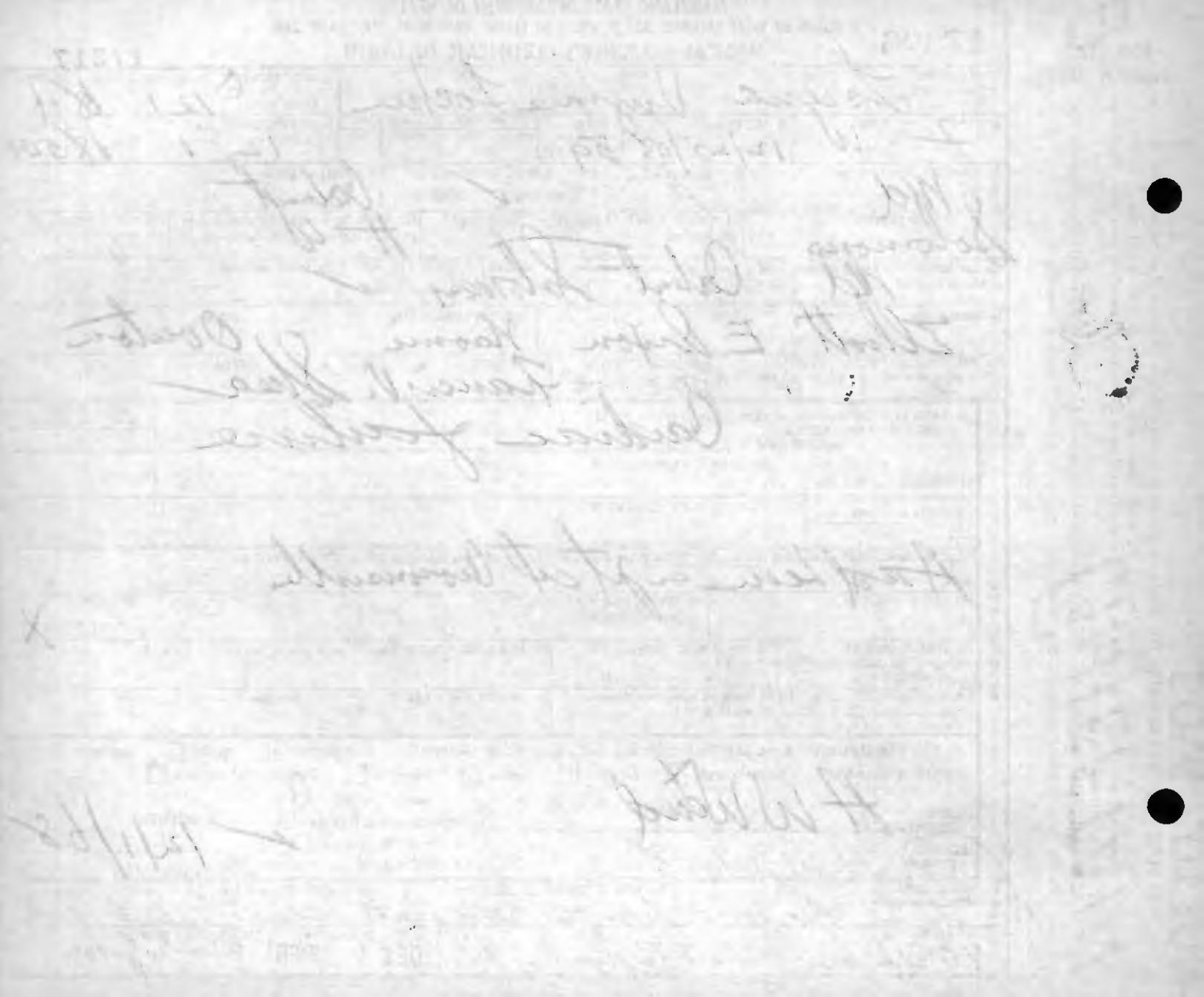
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17305

17317

1. DECEASED NAME (Type or Print)	First	Middle	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
2. SEX	3. RACE	4. DATE OF BIRTH	5. AGE (in years at time of death)	6. IF UNDER 1 YEAR	7. IF UNDER 24 HRS			
7	W	12/25/08	59 YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month 12 Day 1 Year 1968				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Solomons	Cabell Hospital			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residency before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
13b. COUNTY	YES <input type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Elmer	E	Elton		Naome		Oveta		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
No	377-34-0584	Francis V. Spa						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7824 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 7824 (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Had been a patient of Dr. W. Ward								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						
EXAMINER'S NAME (Type)		22b. DATE SIGNED 12/11/68 Owings, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City or Town) Solomons	(County)	(State)		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE DEE 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				
A. A. Kirkauer & Son, Port Republic, Md.								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b. HOURLY 12/12 168 10 P.M
3 SEX <input checked="" type="checkbox"/>	4 RACE <input checked="" type="checkbox"/>	DATE OF BIRTH W 10/12/14	6. AGE (In years In months) 54 yrs	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS DAYS 0	9. IF MIN. HOURS 0	2c DATE PRONONCED DEAD Month 19	Day	Year 19	2d HOUR M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert		Md.	
10. CITY OR TOWN OF DEATH Wharf Beach		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during 90 days immediately preceding death if required)		12b. KIND OF BUSINESS OR INDUSTRY Entomologist				
13a. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) STATE Md		13b. CITY OR TOWN Calvert		13d. INJURE CITY LIM. TSP NO		13e. STREET AND NUMBER 603 Shrub St				
14. FATHER'S NAME Harry J. Mundell		First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Cole	First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16b. SOCIAL SECURITY NO. 57850-6493		17. INFORMANT H. J. Mundell		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7824 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. 1924		DUE TO, OR AS A CONSEQUENCE OF Cardiac failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Was speaking at home weekly & stopped over										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE H. W. Ward		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/12/68		
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 12/17/68		23c NAME OF CEMETERY OR CREMATORIAL Arlington National		23d LOCATION (City or Town) Ft. Myer		(County) (State) Va		
24 FUNERAL DIRECTOR Hutchins		ADDRESS Funeral Home Owings, Md.		25a REC'D BY REGISTRAR DATE DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



17308

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Marie Elizabeth Plitt				2a. DATE OF DEATH December 14, 1968	2b. HOUR 7:00M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 9-8-91		6. AGE (In years last birthday) 77 yrs.	IF UNDER MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert County		
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Calvert	13c. CITY OR TOWN Huntingtown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Neeld Estate	
14. FATHER'S NAME John	First Middle Last Nies	15. MOTHER'S MAIDEN NAME Margaret			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 212-10-0556	17. INFORMANT Carl E. Plitt, Huntingtown, Maryland	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 11-19-68, 19____, to 12-14, 1968, that (I) (we) last saw the deceased alive on 12/12/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George J. Weems</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-14-68
22d. PHYSICIAN'S NAME (Type) George J. Weems, M.D.		22e. ADDRESS Huntingtown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-17-68	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Maryland (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 19 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17308 17320

1. DECEASED NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH MATED	Month	Day	Year	2b. HOU.R 168	6:30a.m
Sadie			Powell			<input checked="" type="checkbox"/>	12	5			
3 SEX female	4 RACE white	5. DATE OF BIRTH 2-11-90	6. AGE (in years last birthday) 78 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN		2d HOUR 6:30 AM		
7a BIRTHPLACE (State or foreign country) Delaware		7b CIT ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert	2c. DATE PRONOUNCED DEAD Month 12		Year 1968
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR IND.STRY Home		
13a. U.S.A. RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland			13c. CITY OR TOWN Queen Anne			13d. INSIDE CITY LIMITS? <input type="checkbox"/>			13e. STREET AND NUMBER Sudlersville		
14. FATHER'S NAME Henry			15. MOTHER'S MAIDEN NAME Williams			16. ADDRESS Catherine			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-50-4279			17. INFORMANT Helen P. Marsellas					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY 885 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)			graduated high								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) fell off cart and graduated high											
19a. DATE OF OPERATION 9/15/68 - 10/31/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED graduated high			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 8-9/16 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) fell while walking					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. Sudlersville, Queen Anne Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Hugh W. Ward, M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPT. MEDICAL EXAMINER <input type="checkbox"/>		
22b. DATE SIGNED 12/5/68											
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE Dec. 7, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Sudlersville Cemetery.			23d. LOCAT ON (City or Town) Sudlersville, Q.A. (County) Md. (State)		
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17340

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17322

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First Elbert	Middle Thomas	Last Wells	2a. DATE OF DEATH Month Dec 12	2b. HOUR Year 1968	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 2, 1881	6. AGE (In years last birthday) 87 yrs.	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert		10d. KIND OF BUSINESS OR INDUSTRY Farmer
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert Co. Nursing H		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13c. CITY OR TOWN Friendship		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Ward		
14. FATHER'S NAME William		Middle T.	Last Wells	15. MOTHER'S MAIDEN NAME Miranda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 212 36 7537		17. INFORMANT Mrs Mary L. King		Address Chesapeake Beach.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca bladder</i> <i>188X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1810</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1/1948</u> to <u>12/12/1968</u> , that (I) (we) last saw the deceased alive on <u>12/12/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Elbert</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/16/68	23c. NAME OF CEMETERY OR CREMATORIUM Friendship Ch. Cem		23d. LOCATION (City or Town) Friendship	(County)	(State) Md
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md		ADDRESS	25a. REG'D. BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

